Addressing Gender Issues and Integrating Gender Activities into the MCHIP Voluntary Medical Male Circumcision Project in Lesotho

Literature Review

June 2013

INTRODUCTION

In May 2012, the Gender Technical Working Group of the President's Emergency Plan for AIDS Relief (PEPFAR) conducted a gender assessment of the Lesotho PEPFAR program. The purpose of the assessment was to review key gender-based barriers, constraints, and opportunities in Lesotho; assess the institutional context supporting gender integration into the PEPFAR country program; identify current activities and programs that are integrating gender and/or could increase gender integration; and offer recommendations to strengthen the PEPFAR HIV/AIDS response in Lesotho. There were a number of recommendations from the gender assessment for the Maternal and Child Health Integrated Program (MCHIP), including conducting a literature review on gender-related barriers and opportunities for voluntary medical male circumcision (VMMC); completing a report on existing gender-related barriers to and opportunities within VMMC and providing recommendations on how to address those barriers/opportunities; conducting meetings with key stakeholders, regional nongovernmental organizations, and United States Government colleagues to identify and address gender-related barriers/opportunities in order to strategize on how to scale-up VMMC; and implementing a plan that addresses gender in the VMMC program. The following brief literature review on addressing gender in VMMC programs, with programmatic recommendations on how to address gender, is a response to the assessment. There is a scarcity of Lesotho- and VMMC-specific research that addresses gender; however, resources from the Southern and Eastern Africa regions were found and included in the literature review. Several Lesotho-specific sources were identified as well. The data presented below will aid the MCHIP Lesotho program in developing a formative assessment protocol. Qualitative research will be conducted in late 2013 to provide answers to some of the identified gaps found in the literature review. Therefore, this literature review, with recommendations on how to address gender in the VMMC Lesotho program, is the first of several steps that MCHIP and partners will take to address the recommendations of the gender assessment of the Lesotho PEPFAR program.

DEFINITION OF THE PREVENTION AREA

Observational and epidemiological studies have shown, and three randomized controlled trials have confirmed, that male circumcision reduces female-to-male HIV acquisition by 60% (Quinn, 2000; Reynolds et al., 2004; Siegfried et al., 2005; Bailey et al., 2007; Gray et al., 2007; Auvert et al., 2005). The results of these three trials has led the international HIV/AIDS community to recommend VMMC in 14 countries where HIV/AIDS is a generalized heterosexual epidemic,

HIV prevalence is high, and complete circumcision in the male population is low (WHO & UNAIDS, 2007). Although the clinical trial results are clear on VMMC's protective benefits for males, there is little evidence on the direct protective benefits for women (Weiss, Hankins, Dickson, 2009).

INDIRECT EPIDEMIOLOGICAL BENEFIT OF VMMC FOR WOMEN

The benefits of VMMC for women are less clear than those for men and there is a scarcity of clinical trial data on the protective factor of VMMC for females. Mathematical models hypothesize that, in the long term, as more males in the community are circumcised, and the HIV prevalence rate is reduced, then women will be less likely to become infected (Hallett et al., 2011; Bollinger, DeCormier Plosky & Stover, 2009). Hallett et al.'s (2011) modeling study estimated there would be an increased benefit to women by reducing male-to-female HIV transmission by 46%. The study concluded that if the reduction begins two years after men are circumcised then infections could be averted by 40% overall and the number of women who are protected could double. It has also been shown that circumcised males are less likely to become infected with sexually transmitted infections (STIs) such as genital ulcerations, trichomoniasis, and high-risk human papillomavirus (HR-HPV), which is a pre-cursor to cervical cancer (Larke, 2010; Weiss et al., 2010; Auvert et al., 2009; Gray et al., 2009); therefore, if the males' rates of STIs are reduced then their female sexual partners would be less likely to become infected as well. Several studies, as well as the Hallett et al. study, have shown the positive health benefits of VMMC on women (Davis et al., 2013; Tobain, Gray, Guinn, 2010; Gray et al., 2009), but more research is necessary for the results to be conclusive.

POSSIBLE EFFECTS OF VMMC ON WOMEN

Joint United Nations Programme on HIV/AIDS (UNAIDS), World Health Organization (WHO), PEPFAR, and women's groups are concerned that VMMC could have an unintended impact on women and advocate for the continual monitoring and evaluation of male circumcision programs to ensure that they maximize benefits and minimize potential harms (Bertrand et al., 2011; AVAC, 2008; UNAIDS, 2008; Hankins, 2007; WHO, 2007). These concerns include an increase in sexual risk-taking behaviors by circumcised men, reduced ability of women to negotiate condom use with circumcised partners, increased stigma and blame for HIV-positive women, and reduced resources for women-centered prevention efforts (Bertrand et al., 2011; AVAC, 2008; WHO, 2007; Hankins, 2007). The Women's HIV Prevention Tracking Project (WHiPT) explored women's perspectives of VMMC in their 2010 study. The study was conducted in five African countries (Kenya, Namibia, South Africa, Swaziland, and Uganda) and found that 64% of women believed that VMMC would change men's views on HIV risk (both positively and negatively), and 54% reported that VMMC would increase gender-based violence. Women in the study also believed that stigma and discrimination against HIV-positive women would worsen. Andersson and Cockcroft (2012) found that some men and women in Botswana, Namibia, and Swaziland had inaccurate beliefs about the benefits of VMMC, such as circumcised men being fully protected against HIV, that HIV-positive circumcised men could not transmit the virus, and that a circumcised man did not need to use a condom. Other countries may have similar misconceptions of VMMC, which could negatively affect women's and men's health; therefore, communication activities addressing these issues must be implemented and programs need to be continually monitored and evaluated to ensure that adverse results do not transpire.

The peer-reviewed literature does not support the fear that circumcised men will increase their sexual risk-taking behaviors post-circumcision in the belief that they will not acquire HIV. Numerous studies have examined males' risky sexual behaviors post-operation and they have shown no differences between circumcised and uncircumcised men (Kong et al., 2012; Gray et al., 2012; Westercamp et al., 2010; Agot et al., 2007, Bailey et al., 2007, Gray et al., 2007). However, these men were either enrolled in clinical trials or were living within the same

catchment area as the clinical trials, so the level of counseling and information could have been more intense compared to programs implemented outside of study sites. A couple of studies have found that the majority of circumcised men behaved more responsibly after the operation (Grund & Hennink, 2012; Riess et al., 2010), but in one study a few participants did report engaging in higher risk behaviors for a short period of time after the operation (Grund & Hennink, 2012).

UNAIDS, WHO, and others stress the importance for circumcised men to practice other HIV preventive behaviors (Bertrand et al., 2011; WHiPT, 2010; Weiss, 2009; UNAIDS, 2008; WHO, 2007). Clearly communicating the partial protectiveness of VMMC to both men and women is vital to help ensure that individuals remain HIV negative. Comprehensive messages should include correct and consistent condom use, delayed sexual debut, reduction of sexual partners, risks of having multiple sexual concurrent partners, abstinence, and being faithful to one HIV-negative partner. Layer et al. (2012) found that the majority of Tanzanian women understood the partial protectiveness of VMMC but, despite this knowledge, the women thought they were still at low risk of acquiring HIV if they had sex with a circumcised man. The two main reasons for their perceived lower risk were improved penile hygiene and fewer abrasions during sex, which had protective factors against HIV infection. Therefore, communicating the partial protectiveness of VMMC is important, but additional and more detailed information must be provided as well to support healthy behaviors.

Another potential adverse result of VMMC for women is HIV-positive men, or men of unknown status who are HIV positive, inadvertently exposing women to HIV before their wound heals or not performing other preventive behaviors post-operation and exposing women to HIV. There is no HIV/AIDS health benefit for HIV-positive men who choose to become circumcised, but it is their right to get circumcised if they choose. Men can also refuse HIV testing, and if they are healthy they can still get circumcised despite the lack of HIV/AIDS preventive health benefits if they are HIV positive. Both circumstances could lead to a higher degree of HIV exposure to women with HIV-positive partners. Wawer et al. (2008) found that HIV-negative women who had an HIV-positive, newly circumcised male partner were at an increased risk of becoming HIV infected if the couple resumed sexual activity before the wound fully healed when compared to other serodiscordant couples who waited the required six weeks before having sexual intercourse. (This trial was stopped early because it did not have sufficient power to determine any direct benefits for the HIV-negative female partners.)

These examples illustrate how VMMC programs could have various unintended consequences on women's health. It is important to continually assess the validity of the above concerns because some concerns could have less of an effect compared to others (e.g., risk compensation versus sex prior to full wound healing). Programs need to be continually monitored and evaluated as they are scaled-up and implemented over the long-term to reduce the potential negative effects, and increase the possible positive effects, on women.

ACCEPTABILITY OF VMMC

Multiple studies have shown that acceptability of and interest in VMMC services are high in many African countries (Albert et al., 2011; Mavhu et al., 2011; Plotkin et al., 2011; Mugwanya et al., 2010; Lukobo & Bailey, 2007; Westercamp & Bailey, 2007). Westercamp and Bailey (2007) reviewed studies exploring the level of acceptability of male circumcision in nine sub-Saharan countries and found that 65% of uncircumcised men were willing to get circumcised and 69% of women favored circumcision for their partners. The majority (71% of men; 81% of women) also was willing to circumcise their male infants/children. The largest positive factors reported by women for VMMC programs were for hygiene and cleanliness purposes and the partial HIV protective benefits. Men mentioned women's desire to be in relationships with circumcised males and the hygiene and health benefits of male circumcision as motivators for

seeking VMMC services. Similar reported benefits were found in the qualitative assessment published in 2011 by MCHIP Tanzania entitled "Embe Halijamenywa: The unpeeled mango," in which the facilitating factors most commonly expressed by women were disease prevention, women's preference for a circumcised man, and cleanliness (Plotkin et al., 2011). Younger men also reported that women prefer having sexual relationships with circumcised men, which would influence them in seeking VMMC services (Plotkin et al., 2011). In the study, women confirmed their preference for circumcised men as well (Plotkin et al., 2011).

IMPORTANCE OF INVOLVING WOMEN IN VMMC PROGRAMS

Many studies have reported on the importance of women as influencers and supporters of men's decision to become circumcised (Plotkin et al., 2011; Obure, 2011; Mugwanya et al., 2010; Westercamp & Bailey, 2007). For example, Mugwanya et al. (2010) found through multivariable analysis that HIV-negative Ugandan men in serodiscordant partnerships were 23% more likely to express interest in getting circumcised if they had discussed it with their partners compared to those who had not. Older men stated in Plotkin et al. (2011) that before accessing VMMC services they needed their spouse's support for the six-week abstinence period for wound healing. The men discussed how their spouses might be suspicious of them if they remained abstinent for such a long period of time; therefore, informing them of the necessary six-week abstinence period was essential.

Many VMMC programs recognize the importance of women's inclusion in programs and target them through communication materials and activities. A number of programs have identified women and mothers as a secondary target population for VMMC communication activities because they influence males in seeking VMMC services, support men in the post-operation abstinence period, help in wound care, and are decision-makers in seeking male circumcision services for their infants/children. According to the Male Circumcision Clearinghouse website, South Africa, Uganda, Zambia, Namibia, and Swaziland have programs that target women. Mahler et al. (2011) described demand creation activities in Tanzania and reported that they targeted female partners of potential VMMC clients. These programs often use brochures, leaflets, and posters to reach female partners of potential clients and mothers of male infants/children. The information contained within these materials often provides factual data on the benefits (e.g., reduced rates of cervical cancer) and risks (e.g., pain) of VMMC as well as dispelling myths and misconceptions (WHiPT, 2010).

More involved activities providing in-depth information and discussion on other social and cultural issues surrounding VMMC programs with women have been limited. One of the most developed communication programs for VMMC is in Kenya; in their 2010 document entitled "Voluntary Medical Male Circumcision (VMMC) Communication Guide for Nyanza Province" the Ministry of Public Health and Sanitation states that the first phase of the communication program should focus on information and knowledge. The next phase of the communication strategy needs to tailor activities to specific target groups, including women. Materials and activities also should be developed and based on the different stages of behavior change for individuals and communities. This seems to be the common communication trend in many countries implementing VMMC. Materials and activities should start with the dissemination of correct and accurate information on VMMC and aim to dispel myths and misconceptions, and then move into more detailed and targeted communication activities based on the context's unique complexities.

All communications surrounding VMMC should be based on the best practices learned from other behavior change and demand creation activities. These include conducting a situational analysis, setting goals and objectives, segmenting key audiences, developing key messages, identifying communication channels, identifying key partners for collaboration, developing and pre-testing tools and materials, and monitoring and evaluating programs (UNAIDS, 2008). The objectives of many of these programs are to disseminate correct and accurate information, dispel

myths and misconceptions, increase knowledge of where and how services are provided, communicate the benefits of VMMC, and increase up-take and demand for VMMC services.

CONTEXT IN LESOTHO

The research data on VMMC in Lesotho is limited but three reports do provide some information—the 2009 and 2004 Demographic and Health Survey (DHS) and the 2008 Situation Analysis Report on Male Circumcision. The 2009 DHS reported that 52% of men 15 to 59 years old self-reported that they were circumcised. This figure included those who were circumcised at health facilities as well as through initiation schools. The Situation Analysis reported that the majority of males circumcised in Lesotho were circumcised through initiation schools, which is most likely similar to the DHS population as well. The 2009 DHS reported that circumcised men had a higher HIV/AIDS prevalence rate compared to uncircumcised men (20.9% versus 17.7%). The national HIV/AIDS prevalence is 23% for adults aged 15-49 years (26.7% for women, 18% for men) (DHS, 2009). These figures suggest that traditional circumcision may be partial and not full since the protective effect of VMMC was not seen and/or men could have become HIV infected prior to being circumcised.

Lesotho has a strong culture of traditionally circumcising older adolescents/young men, and the Situation Analysis showed that some people perceived men who had not gone through initiation school as not being "real" men. In traditionally circumcised areas, stigma was also reported against men who had been circumcised through VMMC services and not the initiation school (Lesotho Situation Analysis, 2008). Similar findings were found in Greely et al. (2013), in which South African men who had been circumcised at a medical facility were not seen as "real" men. The Situation Analysis also reported that there was confusion about the differences between traditional circumcision and VMMC. It was thought that those who believed strongly in traditional circumcision would resist VMMC. Therefore, it will be important for the program in Lesotho to clearly communicate the benefits and conditions (e.g., full versus partial, trained doctors/nurses, use of anesthesia) of VMMC services offered by the Ministry of Health (MOH) and MCHIP. In addition, as was stated in the Situation Analysis, VMMC needs to compliment and not compete with traditional initiation given its importance to the Basotho culture.

One key success of the Lesotho program is that the MOH is following the Situation Analysis's recommendation of complimenting and not competing with traditional initiation schools. For the last several years, the MOH has moved progressively toward the goal of rolling-out VMMC in the country. The MOH has worked with the initiation schools and traditional chiefs to get their approval for the services before actual VMMC service implementation. To ensure that key stakeholders approved of the program, the Lesotho VMMC program began providing male circumcision services after many other Eastern and Southern African countries had started to provide services. The delay in service delivery has given many stakeholders the chance to learn and approve of the services. The Lesotho VMMC program has been successful in recruiting clients for the services through "word of mouth" and has been accepted in the communities.

The data on the level of acceptability of VMMC and some of the motivations and barriers to seeking male circumcision services reported in the Situation Analysis are similar to what research has found in other countries in the region. For example, key informants perceived VMMC as increasing penile hygiene and circumcised men as "clean." Uncircumcised men recognized the benefits of male circumcision such as protecting themselves from STIs and being viewed as more hygienic. Potential barriers reported by men included fear of pain, embarrassment of having female nurses present during the operation, and possible diminished sexual pleasure. Women's views of male circumcision from the Situation Analysis were positive; they reported that circumcised men made sex more pleasurable, were "cleaner," and free of infections. Women in the focus groups reported that they would encourage their husbands to get circumcised because they felt that sex with a circumcised man was more fun and men were not as prone to STIs. A few women reported being fearful since they thought men would believe that they were safe from HIV

and engage in riskier behaviors. It was also stated that mothers make decisions when a male child was to be circumcised at a health facility, but fathers make decisions when a male child was to go to the initiation school.

The Situation Analysis, written prior to the actual implementation of services, stated that scaling-up male circumcision in Lesotho would require a dramatic increase in demand. The lack of awareness of VMMC's health benefits was one reason given for the low demand of VMMC. Other reasons for the lack of demand included the influence of traditional culture and religious beliefs that discouraged men from accessing male circumcision services. Many participants interviewed in the Situation Analysis felt that the population, especially those in rural areas, lacked awareness and correct information on the health benefits of VMMC. Many young men, as stated in the Situation Analysis, thought that if you were circumcised then you would be fully protected against HIV and could never get infected. This misconception supports the key informant's views that the population needed more information and education on VMMC, and it verifies women's fears that some men may engage in higher risk behaviors after VMMC. A national awareness campaign would need to increase knowledge and dispel myths and misconceptions to help increase demand for VMMC.

Communication messages will need to be tailored to areas where male circumcision is common and where it is less common. For example, women who were interviewed from traditionally circumcised areas thought that initiation groomed their sons for manhood and taught them cultural values. Therefore, clearly articulating the benefits of VMMC will be important in this setting while respecting the cultural aspects of traditional circumcision. Women who were from areas where circumcision was not commonly performed thought that circumcision at health facilities was beneficial since it saved time, allowed boys to continue school, was hygienic, and provided good wound care. Other positive aspects of VMMC can be articulated to both groups of women such as the 60% reduction of female-to-male acquisition of HIV, increased penile hygiene, decreased chance of acquiring STIs, the health benefits to women, and focusing on the motivations for seeking VMMC that will be illuminated once a formative assessment is conducted. These positive aspects of VMMC can be capitalized on in both settings.

Lesotho's VMMC program began offering services in February 2012 and demand has been relatively high due to information being disseminated through "word of mouth." Other demand creation activities have been limited. Programmatic data from the last year demonstrated that males 15–19 years old accessed VMMC services the most, followed by males 20–24 years old, then males 25–49 years old. The MCHIP Lesotho program is currently conducting a client views study to gain insights into the motivating factors of those who accessed VMMC. Antidotal information suggests that many youth accessed VMMC because of the HIV protective benefits. Peer influence could be another motivating factor since many youth came into the clinic in large groups from the same high school. Other positive benefits of VMMC services are male's increased access to HIV testing and counseling and reproductive health services, which are both provided at VMMC sites. Individual and group counseling is provided to all male VMMC clients and topics discussed include reproductive health, HIV/STIs, gender-based violence, alcohol use, benefits of VMMC, and preventive behaviors such as reducing multiple partners and correct and consistent condom use. The MOH's VMMC services are provided free of charge and are offered within district hospitals, therefore, males accessing VMMC may access other services since they are within the same clinical care setting.

The Lesotho VMMC Implementation Plan states that the "overall objective of this operational strategy is to contribute to the reduction of the number of new infections by 50% by scaling up VMMC to reach a prevalence of 80% among males aged 15-49 years and neonates by 2016." Therefore, to reach this goal, the MOH stated that they wanted to start implementing demand creation activities in 2013. Demand creation activities have been limited to date with a few

information, education, and communication materials. There are currently two posters and two leaflets—one for females and one for males. The leaflets explain the benefits of VMMC, provide information on post-operation care and the necessity of practicing preventive behaviors post-operation, and other relevant information.

To implement communications activities in the field, MCHIP hired a communications officer in April 2013 and five short-term community mobilization officers, two females and three males, in June 2013. Additional communication materials are currently being developed, which will target older male youth (18–24 years), younger male youth (<18 years), adult men (>24 years), wives/girlfriends of potential clients, health staff and community leaders, and mothers of male infants/young children. MCHIP will also develop a tool for the community mobilization officers to use in the field. With the additional staff, communication activities are being scaled-up; the initial focus is with male high school and university students because they tend to be the first VMMC adapters, according to programmatic data from the last year. As the community activities roll-out in June–September 2013, a more focused and organized effort will be made to reach women and harder-to-reach men.

POTENTIAL OPPORTUNITIES TO ADDRESS GENDER IN LESOTHO'S VMMC PROGRAM

There are a number of opportunities in the MCHIP VMMC program to address gender. They include:

- **National VMMC Communication Strategy:** A National VMMC Communication Strategy will enable the program to gain national leadership and support to address all communication issues surrounding the program, including gender. A formative assessment will be conducted to explore the populations' (e.g., female partners of potential clients and mothers of male infants/children) values, beliefs, opinions, motivating factors, and barriers surrounding VMMC. The results of the formative assessment will help provide the data necessary to ground the strategy in the Basotho context. The strategy will list the expected outcomes, primary/secondary audiences, and objectives; detail the analysis of the audiences; and provide an overview of the communication approach, desired behaviors, and strategies and interventions per audience and level (e.g., national, district, community, group, individual, facility). An implementation plan will be provided in the strategy that outlines the roles and responsibilities of each stakeholder.
- **Ensuring Community-Level Involvement:** The development of the National VMMC Communication Strategy could be the catalyst to begin discussions on how to involve the community in VMMC services as well as to decide who would be responsible for those activities. Mahler et al. (2011) describe how district-level demand creation subcommittees were organized. These subcommittees were composed of district officials, health staff, and international and community-based organizations and were responsible for demand creation in their catchment area and for working with political and community leaders. Lesotho could do something similar, but in a step-by-step fashion as has been their approach to implementing VMMC services.

The communication staff at MCHIP should work with women's groups at the community level to inform them of the benefits of VMMC, dispel myths and misconceptions, as well as discuss gender-specific issues such as post-operation preventive behaviors, the six-week abstinence period needed for wound healing, couples counseling and testing, sexual decision-making with partners, and gender-based violence. Research findings state the importance of providing adequate counseling and education to wives and partners of VMMC clients so they understand and support men through the healing and abstinence period. Educating the women about the abstinence period could lower their chances of having extramarital relationships (Mwandi et al., 2011; Plotkin et al., 2011). In addition, community mobilizers could provide and demonstrate the use of male and female condoms (WHiPT, 2010; WHO, 2007).

A further opportunity will be to target factory workers (90% of whom are women). In this regard, MCHIP has already begun collaboration with the Apparel Lesotho Alliance to Fight AIDS (ALAFA) to ensure factory workers' partners are reached with HIV testing and counseling and male circumcision services. Female factory workers can also be provided with messages to ensure support for their newly circumcised husbands/boyfriends.

The communication staff at MCHIP should work at the community level with groups of men such as taxi associations and workplaces to inform them of the benefits of VMMC and dispel myths and misconceptions. Some advocate that VMMC is a vital gateway in accessing men to educate them on issues such as reproductive health, family planning, PMTCT, gender equality, and gender-based violence (Bertrand et al., 2011; Ngooyi, 2011; WHiPT, 2010). Counseling and communication activities, with accompanying materials, should be used to encourage men to discuss VMMC with their partners for joint decision-making, the six-week abstinence period needed for wound healing, couples HIV counseling and testing, and sexual decision-making with partners (Mwandi et al., 2011). MCHIP's draft counseling materials incorporate many of these topics for men seeking VMMC services. The program could build on this information by also providing men with information on other health services as well as increasing their overall health-seeking behavior. Community mobilizers could provide and demonstrate the use of male and female condoms (WHiPT, 2010; WHO, 2007). The program also could clearly distinguish the differences between VMMC and female genital mutilation, and traditional circumcision and VMMC in all program literature and communications (WHiPT, 2010).

Group and Individual Activities

Community Mobilization Officers: Community mobilizers can canvas the community through use of small-group and individual discussions on VMMC. MCHIP's two female and three male community mobilization officers can target specific groups based on their composition. For example, when canvasing the community, teams of one female and one male can work together. Other times, the men and women community mobilizers can separate to visit and work with women-only and men-only groups such as PMTCT and maternal and child health facilities/services or at men-only workplaces and establishments such as mines and bars to address their specific needs and questions based on programmatic and study-specific data. In addition, mobilizers could inform men of other health services in the area to increase their overall health-seeking behavior. Community mobilizers could also provide male and female condoms and perform condom demonstrations (WHiPT, 2010).

Increase Couple Communications: Community mobilizers and/or VMMC counselors could work with couples to communicate the need for couples to get HIV testing and counseling, as well as the partial protection of VMMC, VMMC's health benefits, six-week abstinence period post-operation, and the need to use safe sexual practices after circumcision. Discussions could emphasize that the amount of protection for women is not yet known, and the woman's risk of HIV depends on her partner's status and both partners' sexual behavior. VMMC services can promote couple's voluntary counseling and testing since it has shown to increase communications between couples about HIV, the likelihood of disclosing one's HIV status to the partner, and the preventive sexual practices after VMMC (Lanham et al., 2011). WHiPT found that the majority of women wanted to be involved in the VMMC decision-making process with their partners, but only 36% felt they had the ability to be involved. WHiPT recommended increasing the involvement of female partners in VMMC programs.

Facility-Based Activities: The MCHIP program is a service delivery program providing safe and affordable male circumcision services to the Basotho population. VMMC services began in February 2012 and many male-specific activities have already been implemented. For example, males seeking VMMC have access to HIV testing and counseling and STI services, and are provided with group and individual counseling, which covers topics such as safer sexual practices, family planning, and

gender-based violence. VMMC is provided in the hospital setting, which provides men with the opportunity to access other health services since they are already within the clinical care setting.

MCHIP, in partnership with the MOH, plans to expand services to men through the development of male health clinics. A pre-fabricated clinic will be purchased by December 2013, which will provide VMMC and other services specifically for men. Services could include reproductive health, blood pressure, diabetes, colon and penile cancer screening, and eye/ear/dental exams. MCHIP is also planning to ensure that Early Infant Male Circumcision (EIMC) services include large maternal, newborn, and child health (MNCH) components as well as support the right of mothers to sign informed consent for circumcising their newborns. Communication materials on infant male circumcision and consent forms will be available at health care facilities where women are giving birth. Additional MNCH services could include nutritional counseling for infants under one year of age; counseling on breastfeeding, and formula and supplemental feeding; tracking weight, height, and head circumference throughout the first year; diarrhea prevention and treatment; vaccinations; breast care; screening and treatment for anemia; and family planning.

Other opportunities at the facility could include educational activities for men as they are queuing for services to reach them with gender-norm messages, including gender-based violence and partner testing. A key learning opportunity occurs when men come back to the clinic for their 48 hour, seven-day, and six-week follow-up appointments. Men may be more relaxed during the follow-up appointments compared to when they first arrive for the circumcision procedure; therefore, they may be more receptive to health and social messages at that time. MCHIP is exploring the possibility of producing a video on Basotho-specific gender issues, which can be shown during the follow-up visits. A counselor, or other appropriate staff member, can then lead a discussion on the issues raised in the video. Other opportunities include having community mobilization officers inform men of male-specific clinical services in their community, and ensuring that VMMC facilities provide both male and female condoms.

Monitoring, Evaluation and Research: Continual monitoring and evaluation are needed to reduce the possible unintended effects of VMMC on women (UNAIDS & WHO, 2007). The program can also review health and social indictors that are collected at the national level.

There is a lack of information on the social, cultural, and gender issues surrounding male circumcision in Lesotho. To learn more about these information gaps, the MCHIP Lesotho program is currently conducting a client views study to explore why clients sought VMMC services as well as to gain the clients' perceptions on the community's norms and attitudes related to circumcision. Some of the questions in the questionnaire pertain to the motivating factors in seeking services, including who may have influenced them in accessing VMMC (e.g., partners, peers).

In addition to the client views study, additional research should be conducted to explore the population's views, opinions, beliefs, and values surrounding VMMC. The VMMC Situation Analysis was conducted in 2008 before services were widely available and prior to the wider dissemination of VMMC information; therefore, it would be beneficial to the program to have a clearer insight into the views on VMMC of potential clients, their partners, and others and their perceived motivators and barriers to seeking services. Other possible areas to explore is the level of female genital mutilation in Lesotho and the effects of VMMC promotion on the practice, how VMMC can be effectively and appropriately placed in a traditionally male circumcising culture, understanding what are the myths and misconceptions within the Basotho culture, and identifying the primary sources of information on VMMC for men and women. These areas could be explored in a formative assessment through interviewing both men and women, segmented by age and urban/rural areas. The findings could then be incorporated into the National VMMC Communication Strategy.

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